STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: The Hospital of Central Connecticut at New Britain General and Bradley Memorial of New Britain – Licensee
d/b/a The Hospital of Central Connecticut
100 Grand Street
New Britain, CT 06050

CONSENT AGREEMENT

WHEREAS, the Hospital of Central Connecticut of New Britain General and Bradley Memorial of New Britain (hereinafter the "Licensee") has been issued License No. 0052 to operate a General Hospital known as The Hospital of Central Connecticut (hereinafter the "Facility') under Connecticut General Statutes Section 19a-490, by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on August 11, 2008 and concluding on September 3, 2008, in order to determine the Licensee's compliance with the provisions of the Regulations of Connecticut State Agencies; and

WHEREAS, the Department, during the course of the aforementioned inspections, identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies were identified in an amended violation letter dated May 6, 2009 (Exhibit A – copy attached); and

WHEREAS, the Licensee, without admitting any wrongdoing, is willing to enter into this Consent Agreement and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department, acting herein and through Joan Leavitt, its Section Chief, and the Licensee, acting herein and through Laurence Tanner, its President and CEO, hereby stipulate and agree as follows:

1. Within fourteen (14) days of the execution of this Consent Agreement, the Facility shall develop and/or review and revise, as necessary, policies and procedures related to:
    a. Radiology safety precautions and practices regarding a pregnant patient undergoing nuclear and radiology testing/procedures;
    b. Procedure to address monitoring and/or removal of peripheral and central access catheters;
    c. Patient assessments for those patients who require behavioral health evaluations in the Emergency Department;
    d. Accurate and complete medical record documentation to include time of order and/or procedure; and
    e. Prevention, assessment, monitoring, and treatment of pressure ulcers and/or wounds.
2. Within twenty-one (21) days of the review and/or revision of policies identified in paragraph one (1), all applicable Facility staff shall be inserviced, as necessary, regarding said policies.
3. The Licensee shall execute a contract with an Independent Wound Care Nurse (IWC) approved by the Department within two (2) weeks of the effective date of this Consent Agreement. The IWC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the IWC.
4. The IWC shall function in accordance with the FLIS' INC Guidelines (Exhibit B – copy attached). The IWC shall be a registered nurse with additional credentialing in wound care and who holds a current and unrestricted license in Connecticut. The Registered Nurse (RN) assuming the functions of the IWC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
5. The IWC shall have a fiduciary responsibility to the Department.
6. The IWC, within two (2) weeks after the execution of the contract with the Licensee, shall provide consulting services to perform an assessment of the Facility's wound program. Following issuance of the IWC's report and recommendations on such

assessment, the IWC shall return within four (4) weeks to reassess the Facility's compliance with the IWC's recommendations.

7. The IWC shall confer with the Licensee's Administrator/Chief Executive Office/Chief Nursing Officer and other staff determined by the IWC to be necessary to the scope of his/her duties and responsibilities regarding pressure sore prevention and care.
8. The IWC shall make recommendations to the Licensee's Administrator/Chief Executive Officer and Chief Nursing Officer, regarding the assessment of patients at risk for pressure sores, identification of plans of care to reduce or ameliorate pressure sores, monitoring of changes, implementing of care plans and staff education. If the IWC and the Licensee are unable to reach an agreement regarding the IWC's recommendation(s), the Department, after meeting with the Licensee and the IWC shall make a final determination, regarding the IWC's recommendation(s), after it receives and considers relevant input and information from the facility, which shall be binding on the Licensee.
9. The IWC shall report to the Department after the assessment and again after the four (4) week reassessment described in Paragraph 6 of this Consent Agreement. The IWC's reports to the Department shall document:
    a. The assessment of care and services provided to patients at risk for or with actual skin impairment; and
    b. Any recommendations made by the IWC and the Licensee's response to implementation of the recommendations.
10. Copies of all reports shall be simultaneously provided to the Chief Nursing Officer and the Department.
11. The IWC shall have the responsibility for:
    a. Assessing and monitoring of patients at risk for and with actual pressure ulcers and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses; nurse aides; and implementing prompt training and/or remediation in any area in which a staff member demonstrated a

deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department.

12. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Agreement shall be provided to the IWC and the Department, upon request.
13. The Department shall retain the authority to extend the period the IWC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance regarding pressure sore prevention and care. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of the onsite inspections conducted by the Department.
14. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Agreement. The name of the designated individual shall be provided to the Department within said time frame. Said individual assigned this responsibility shall submit reports at six (6) week intervals, which address components of this document to the Department.
15. Within thirty (30) days of the execution of this Consent Agreement, the Licensee shall establish a mechanism, whereby the Licensee's Quality Assurance Program, on an ongoing basis, reviews and evaluates the following:
    a. Prevention and care of patients at risk for and/or with skin impairment.
16. The Licensee's Administrator and Chief Nursing Officer shall confer with the Department every six (6) weeks for the first three (3) months after the effective date of this Consent Agreement and thereafter at three (3) month intervals throughout the duration of this Consent Agreement.
17. The Department shall retain the authority to extend, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.

18. Effective upon the execution of this Consent Agreement, the Licensee, through its Governing Body, Administrator and Chief Nursing Officer, shall ensure substantial compliance with the following:
    a. Patient assessments, inclusive of skin risk assessments, are performed in a timely manner, documented and accurately reflected the condition of the patient;
    b. Each patient care plan is reviewed and revised, as necessary, to reflect the individual patient's problems, needs and goals, based upon the patient skin risk assessments and in accordance with applicable Federal and State Laws and Regulations;
    c. The personal physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity and/or presence of any infection;
    d. Patients with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
    e. Necessary pressure relieving devices are provided to patients at risk for and/or with actual skin impairment; and
    f. A mechanism for ascertaining pregnancy status in women of child-bearing age prior to performance of radiologic procedures.
19. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand five dollars ($2,500.00) by money order or bank check payable to the treasurer of the State of Connecticut and mailed to the Department within two (2) weeks of the effective date of this Consent Agreement. The money penalty and any reports required by this document shall be directed to:

Cheryl Theriault, Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12FLIS
P.O. Box 340308
Hartford, CT 06134-0308

20. All parties agree that this Consent Agreement is an Agreement of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its germs is at issue. The Licensee retains all of its rights under applicable law.
21. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
22. The Licensee understands that this Consent Agreement and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the License of any rights that it may have under the laws of the State or Connecticut of the United States.
23. The Licensee had the opportunity to consult with any attorney prior to the execution of this Consent Agreement.

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Licensee: The Hospital of Central Connecticut at New Britain General and Bradley Memorial of New Britain

WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below.

The Hospital of Central Connecticut at New Britain General and Bradley Memorial of New Britain – Licensee

5/12/09
Date

By: Laurence Tanner
Laurence Tanner, President & CEO

STATE OF CONNECTICUT)

County of HARTFORD) ss May 12, 2009

Personally appeared the above named Laurence A. Tanner and made oath to the truth of the statements contained herein.

My Commission Expires:
(If Notary Public)

Notary Public [ ]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [✓]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

May 19, 2009
Date

By: Joan D Leavitt
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 25

May 6, 2009

Laurence Tanner, President & CEO
The Hospital of Central Connecticut
100 Grand Street
New Britain, CT 06050

This is an amended edition of the original violation letter dated October 30, 2008.

Dear Mr. Tanner:

Unannounced visits were made to The Hospital of Central Connecticut commencing on August 11, 2008 and concluding on September 3, 2008 by representatives of the Facility Licensing and Investigations Section of the Facility Licensing & Investigations Section for the purpose of conducting multiple investigations, a substantial allegation survey and to review implementation of the plan of correction to the violation letter dated November 14, 2007.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for October 28, 2008 at 1:00 P.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Cheryl Theriault R RN, BSN

Cheryl Theriault, R, BSN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CEM:lsl
c. Director of Nurses
Medical Dirctor
President
CT #'s 8192, 8162, 7316, 8041, 8148, 7913, 7780, 7781,
8170, 6758, 7602, 7518, 7090, 7826, 7329, 7812

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

EXHIBIT A

DATES OF VISITS: Commencing on August 11, 2008 and concluding on September 3, 2008

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2).

1. Based on clinical record reviews, review of facility documentation and interviews with facility personnel for Patient #11, Patient #35 and Patient #36, the facility failed to provide a written response after a grievance was submitted. The findings include:
   a. Patient #11 was admitted to the hospital for a breast biopsy on 10/11/07. Review of the clinical record identified that at 7:00am an IV line was started. At 8:53am, Patient #11 was sent to radiology and returned to the pre-operative area at 9:22am. Review of the ambulatory surgery admission assessment identified that at 10:40am, the patient had +4 edema/infiltrate, no redness with the IV being removed and her arm elevated. Review of hospital documentation identified that a grievance was sent by Person #5 on 11/13/07 related to the IV infiltration of Patient #11. Further review identified that although a telephone call was made by the Nursing Director of the Operating Room on 11/16/07, a formal letter was not sent to the complainant. Review of hospital policy identified that a final response in writing is required for complaints classified as a grievance.
   b. A review of hospital grievances from the period 5/14/08 to 7/16/08 were reviewed on 8/14/08. Grievances regarding Patient #35 and #36's care and services provided by the Hospital were received on 7/16/08 and 6/25/08, respectively. A review of Hospital documentation on 8/14/08 identified that for Patient #35 and Patient #36, the Hospital failed to respond to grievances in a written format per hospital policy. The policy and procedure, titled "Complaint/Grievances from Patients and Families", identified that the hospital must respond to a grievance in writing in a timely manner.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

2. Based on clinical record reviews and interviews with facility personnel for two sampled patients (Patient #9 and #11), the facility failed to ensure that patient's receiving IV fluids are monitored and treated when they developed a complication and/or failed to ensure that a discharge note was completed at discharge. The findings include:
   a. Patient #11 was admitted to the hospital for a breast biopsy on 10/11/07. Review of the clinical record identified that at 7:00am an IV line was started. At 8:53am, Patient #11 was sent to radiology and returned to the pre-operative area at 9:22am. Review of the ambulatory surgery admission assessment identified that at 10:40am, the patient had +4 edema/infiltrate, no redness with the IV being removed immediately and elevated her hand. Further review failed to reflect when the IV was started including the catheter size, solution and location. Also, the clinical record failed to identify when the patient was sent to/from radiology. In addition, review of the clinical record failed to identify that the IV site was assessed and monitored. Further review failed to reflect that an infiltrated IV site was treated per hospital policy. Review of hospital policy identified

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

that when an IV site is inserted, documentation includes when started, catheter size, location and by whom. Further review identified that when a patient has an IV infiltrate, initiate treatment for IV sites greater than 2+ on the phlebitis scale and document treatment given to IV sites with complications. Interview with the Director of the Operating Room on 8/12/08 identified that nurses are to document IV site, location, intraveous fluids hung, complications and where the patient is to go from the pre-operative area.

b. Patient #9 was admitted to the hospital on 11/13/07 for laparoscopic gastric banding. Review of the nurses notes and hospital documentation dated 11/14/07 identified that the patient was last assessed at 9:00am and discharged to home at 2:45pm. Further review of the nurses notes failed to reflect that a discharge note was completed at discharge. Review of hospital policy identified that upon discharge, the nurse must document a discharge note, mode of discharge and resolve problems on the nursing care plan. Interview with the Nursing Director of N2 on 8/12/08 identified that a discharge note was not completed for Patient #9.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (i) General (6).

3. Based on clinical record review, review of hospital policy, procedures, documentation and staff interviews for one patient (Patient #9), the facility failed to ensure that appropriate consultations were obtained prior to surgery and/or patient (Patient #13), the facility failed to ensure that the patient received timely medical treatment to address the patient's complaints of pain and/or clearly direct the administration of pain medication and/or for Patient #1, the physician failed to remove the central venous access according to their policy and procedure. The findings include:
   a. Patient #9 was admitted on 11/13/07 for a laparoscopic gastric banding. Review of the preoperative pulmonary clearance dated 10/1/07 indicated that the patient was cleared for planned gastric banding procedure however the physician indicated that the patient had significant amounts of noctural bradyarrhythmia of almost 50% of the entire recording showing a pulse rate less than 50 and recommended a cardiac evaluation before surgery. Further review failed to identify that a cardiac evaluation was completed prior to surgery. Interview with MD #23 indicated that he thought the patient had a stress test (7/07) and did not get a cardiac evaluation prior to surgery. Interview with the Chief of Surgery on 8/13/08 identified that the patient should of had a cardiac evaluation prior to surgery.
   b. Patient #1 arrived at the hospital on 3/17/08 at 11:06 P.M. with the complaint of persistent dizziness, syncope, weakness, nausea, vomiting and chest pain. Patient #1 was admitted to the hospital's critical care unit on 3/27/08 with the diagnoses of dizziness, fever, hypotension, syncope, gastrointestinal bleed, tachycardia and anemia. The patient's critical care stay included treatment for sepsis secondary to the cholangitis, hypotension, septic cardiomyopathy, herpes simplex infection and Adult Respiratory Distress Syndrome. Patient #1 was transferred from the critical care area to a nursing

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

unit on 3/27/08 to prepare for discharge. On 4/2/08 MD #10 removed the central venous catheter access, which was located in the left side internal jugular (IJ) vein. Review of the clinical record identified that 3-4 minutes after the central venous access line was discontinued, Patient #1 experienced shortness of breath, palpitations, then became unresponsive (observed while sitting in a chair and visiting with family). A cardiac resuscitation was initiated on Patient #1 on 4/2/08 at 5:07 P.M. The patient experienced hypoxia, hypotension, was intubated and placed on mechanical ventilation then transferred back to the critical care unit. Review of the clinical record for 4/2/08 failed to reflect an assessment of the catheter site- including edema, erythema, drainage, warmth and/or tenderness and/or the rationale for not maintaining direct pressure on the site for 10-15 minutes (according to the hospital policy and procedure). Review Interview with MD #10 on 8/19/08 identified that on 4/2/08 she informed Patient #1 that she was going to remove the left side IJ catheter, placed the patient in Trendelenberg position, removed the dressing, directed the patient to take a deep breath and hold it, removed the catheter, applied pressure to the site for 3-5minutes and applied a gauze dressing to the site and adhered it with tape. MD #10 added that she did give Patient #1 permission then to get out of bed and sit in a bedside chair. Interview with MD #11 on 8/19/08 identified that pulling out a central venous catheter with "not perfect technique" caused Patient #1 to experience shortness of breath, palpitations, unresponsiveness and subsequently an altered responsive state and one sided body weakness. Interview with MD #12 on 8/25/08 identified that it was most likely that the removal of the central venous access line on 4/2/08 caused Patient #1 to be unresponsive and hypoxic. Review of the Hospital policy and procedure, titled "Central Venous Catheter in Critical Care, Removal of" identified that after the catheter is removed the practitioner applies direct pressure for 10-15 minutes over the insertion site until the bleeding stops, the patient's status is assessed 10 minutes after the removal and documentation of the procedure includes the patient's condition before and after the removal of the catheter and the assessment of the site-including edema, erythema, drainage, warmth and/or tenderness.

c. Patient #13 had a diagnosis of Sickle Cell Disease and was admitted to the Emergency Department (ED) on 6/22/07 with complaints of chest pains and difficulty breathing. The ED triage record identified that the patient arrived at the ED at 12:17 AM and was triaged as an urgent admission with a pain score level of "9" on a scale of 1-10. Although the ED Physician assessed the patient and entered orders for care at 1:11 AM, orders to direct care regarding the patient's pain were not prescribed until 1:49 AM on 6/22/07 (1 hour 32 minutes after admission). The discharge summary dated 7/7/07 identified that the patient had a diagnosis of acute chest syndrome. Interview with the Hematologist on 8/18/08 at 1:30 PM noted that acute chest syndrome was medically urgent. Treatment of sickle cell crisis included fluids and pain medication.
d. Patient #13 was admitted to the North 3 unit on 6/22/07 with a diagnosis of Sickle Cell Disease and pneumonia. Nursing documentation and medication record dated 6/25/07 noted that the patient had a target pain score of "2", received pain medication at 12:10

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

AM and 3:10 AM, and was reassessed to be a level "5" after each medication administration. Nursing narratives dated 6/22/07 at 3:41 AM indicated that the patient was yelling out with complaints of pain, the covering physician assistant was notified at 5: 25 AM and the patient's pain medications were not adjusted or additional medications were not ordered to address the patient's pain. The patient's Attending Physician assessed the patient at 7:50 AM, documented that the patient had severe pain all over and increased medications were ordered and administered.

The facility pain policy identified that accurate assessment, frequent evaluation and adjustment of medication and treatments to achieve satisfactory pain levels for a patient experiencing pain can improve quality of life. Obtain a patient's goal for pain control on a scale of 0-10. The institution standard is less than or equal to "3" but, the patient may state a different personal goal for control.

e. Patient #13's ED Physician orders dated 6/22/07 directed Dilaudid 2milligrams IV/IM for pain. Nursing documentation identified that Dilaudid was administered IV push at 2:54 AM on 6/22/07. The facility medical staff rules and regulations identified that the practitioner's orders must be clear. The hospital medication policy identified that a valid medication order consisted of the drug name, dosage, frequency and route (not routes) of administration.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

4. For three (3) of four (4) patients reviewed who were identified to be at risk to fall, Patient's #30, 31 and 32, the facility failed to ensure that the patients were wearing a yellow wristband as per facility policy to alert staff of a patient's risk to fall. The findings were based on review of the clinical records, review of facility policies, observations and interviews, and include the following:
   a. Patient #30 was admitted to the facility on 8/6/08 with diagnoses that included psychosis. Review of the clinical record identified a Hendrich Fall Risk assessment dated 8/12/08 that identified Patient #30 with a score of five (5). Review of the care plan dated 8/12/08 identified Patient #30's risk to fall with interventions that included implementation of the facility's fall risk program. Interview with Nurse Manager #4 at the time of the observation on 8/13/08 identified that the facility's fall risk program included that patients assessed to be at risk to fall would be identified by wearing a yellow wristband. Observation of Patient #30 on 8/13/08 at 1:40 PM identified that the patient was not wearing a yellow wristband in accordance with facility policies.
   b. Patient #31 was admitted to the facility on 6/15/08 with diagnoses that included chronic Schizophrenia. Review of the clinical record identified Hendrich Fall Risk assessments dated 6/15/08 through 8/12/08 that identified Patient #31 with a score of seven (7). Review of the care plan dated 8/12/08 identified Patient #31's risk to fall with

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

interventions that included implementation of the facility's fall risk program. Observation of Patient #31 on 8/13/08 at 1:50 PM identified that the patient was not wearing a yellow wristband in accordance with facility policies.

c. Patient #32 was transferred to the Behavioral Health Unit on 8/12/08 from an inpatient medical unit for additional services. Review of the clinical record identified a Hendrich Fall Risk assessment dated 8/11/08 that identified Patient #32 with a score of five (5). Review of the care plan dated 8/12/08 identified Patient #32's risk to fall with interventions that included implementation of the facility's fall risk program. Observation of Patient #32 on 8/13/08 at 1:55 PM identified that the patient was not wearing a yellow wristband in accordance with facility policies.

Review of the facility's policies for the Fall Risk Prevention Program identified that patients identified as scoring a five (5) or greater through the Hendrich Fall Risk assessment process would be considered at high risk to fall and that required interventions included a fall identifier bracelet (yellow wristband) be placed on the patient.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Services (1) and/or (f) Diagnostic and Therapeutic Facilities and/or (i) General (6).

5. * Based on clinical record reviews, review of facility policies, review of facility documentation, observations and interviews, the facility failed to ensure that nursing assessments of pressure ulcers included complete and/or accurate measurements, descriptions, and/or staging and/or that consistent treatments were provided for three (3) patients, Patient's #6, 8 and 18, who entered the facility without skin impairment and developed pressure ulcers during the hospitalization and/or for one (1) patient (Patient #24), the facility failed to ensure that accurate skin assessments were completed. The findings include:
   a. Patient #8 was admitted to the facility on 12/29/07 with diagnoses that included End Stage Renal Disease (ESRD) and Diabetes. Review of the nursing admission assessment dated 10/26/06 identified that Patient #8's skin was intact upon admission. Review of the Braden score assessments dated 12/29/07 through 1/17/08 identified that Patient #8 was at risk to develop pressure ulcers. The clinical record dated 12/30/07 identified that Patient #8 had developed a Stage I pressure area on the coccyx but lacked documentation of measurements and/or other description of the pressure area. On 12/31/07, Patient #8's pressure area was documented as a 2.0 centimeter (cm.) by 1.0 cm. area on the left buttocks and a 1.0 by 1.0 cm. area on the right buttocks and that a Duoderm was applied. On 1/3/08, the documentation identified Patient #8's coccyx area as a Stage II pressure area with a discolored area identified as a Deep Tissue Injury (DTI), at the center of the wound that measured 5.0 by 2.0 cm. and with a total affected area of 11.0 by 9.0 cm. A Versiva dressing was applied. Two days later on 1/5/08, the sacral dressing was changed but documentation was lacking of a description of the area

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

and/or response to the current wound treatment. On 1/7/08, Patient #8's pressure ulcer on the coccyx area was downstaged to an "excoriation" and barrier cream was applied. Later on the same date, the documentation by another nurse identified the area as a Stage II pressure ulcer with pink, red, and white maceration, and a Duoderm dressing was applied. On 1/8/08 at 10:56 PM, the documentation identified an observation of an excoriation, Xenaderm was applied, but failed to document measurements of the area. On 1/9/08 at 9:08 AM, the documentation identified the area as a Stage II pressure ulcer on the left buttocks that measured 11.0 by 3.0 cm. and a Stage II area on the right buttocks that measured 10.0 cm. by 2.0 cm., both with a scant amount of serosanguineous drainage, and a black and yellow area on the coccyx measuring 3.5 cm. that was also identified as a Stage II pressure ulcer. On the morning of 1/9/08, the patient's coccyx area was described only as excoriated but at 5:10 PM, the area was described as a DTI that measured 5.0 cm. by 3.0 cm. surrounding a Stage II pressure area. On 1/10/08 at 3:48 AM, the coccyx area is described as a Stage IV pressure ulcer with necrotic tissue/eschar. Twelve hours later at 3:56 PM on 1/10/08, the area is downstaged again and described as a Stage II pressure ulcer that was pink, excoriated, with drainage, and Xenaderm ointment was again applied. On 1/12/08 at 9:15 AM, Patient #8's pressure ulcer was identified as Stage III with ecchymoses and undermining but downstaged again on 1/13/08 at 4:41 PM to a Stage II. On 1/14/08, Patient #8's ulcer measured 13.0 by 8.0 cm. with a moderate amount of brown and yellow malodorous drainage. On 1/15/08 at 4:31 PM, Patient #8's pressure ulcer was downstaged to a Stage I, and then back to a Stage II at 1:57 AM on 1/16/08, to a Stage III at 9:29 AM on the same day, and then again downstaged, despite a description of necrotic/eschar tissue, to a Stage II at 12:41 AM on 1/17/08. Patient #8 was discharged to Extended Care Facility #2 (ECF #2) on 1/17/08. Review of the nursing admission assessment from ECF #2 dated 1/17/08 at 7:00 PM identified that Patient #8 entered the facility with a 6.0 by 6.0 by 0.3 cm Stage III pressure ulcer with a yellow wound bed and a small amount of malodorous, purulent drainage.

Patient #8 was readmitted to the hospital on 1/18/08, one day after admission to the ECF. Review of the interagency referral form from ECF #2 identified that Patient #8 had a Stage III pressure ulcer on the coccyx. Review of the hospital nursing admission assessment dated 1/18/08 at 5:10 PM identified that the patient's pressure ulcer was downstaged to a Stage II. Twenty four hours later, the nursing assessment dated 1/19/08 at 5:39 PM identified the pressure ulcer as unstageable. Physician orders dated 1/19/08 directed a new treatment to include the use of a debriding agent. A surgical consult was obtained on 1/21/08, the pressure ulcer was debrided on 1/24/08, and Patient #8 was identified to have a Stage IV pressure ulcer.

A review of a subsequent admission for Patient #8 (2/10/08 to 3/29/08) identified that the patient developed an area of eschar behind the left ear on 2/14/08 where the patient's nasal cannula rested. The documentation identified that soft padding was placed behind

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the patient's left ear on 2/14/08 but lacked measurement of the area. Documentation on 2/15/08 identified that Patient #8's left ear area was necrotic but lacked measurement of the area and/or description of surrounding skin and/or treatment to the area. Review of the clinical record from 2/15/08 through the time of the patient's discharge on 3/29/08 failed to identify any further monitoring or treatment to the necrotic area on Patient #8's left ear.

b. Patient #6 was admitted to the facility on 10/26/06 with diagnoses that included an exacerbation of Congestive Heart Failure (CHF). Review of the nursing admission assessment dated 10/26/06 identified that Patient #6's skin was intact upon admission. Review of Braden score assessments dated 10/26/06 through 11/2/06 identified that Patient #6 was at risk to develop pressure ulcers with scores that ranged from thirteen (13) to seventeen (17). On 11/1/06, the documentation identified that Patient #6 had developed a Stage II pressure ulcer on the coccyx and that a Duoderm dressing was applied, but lacked documentation of measurements of the area and/or a description of the surrounding skin. Patient #6 was discharged to Extended Care Facility #1 (ECF #1) on 11/2/06. Review of the nursing admission assessment from ECF #1 dated 11/2/06 at 1:30 PM identified that Patient #6 arrived at the facility with a Stage II pressure ulcer on the right buttocks that measured 1.0 centimeters (cm.) by 0.5 cm. with excoriation over both the right and left buttocks and coccyx area. Interview with Clinical Nurse Specialist #2 on 8/12/08 at 2:30 PM identified that upon identification of a new pressure ulcer, facility staff was expected to measure and describe the pressure ulcer and provide documentation of their assessment in the clinical record.

c. Patient #18 was admitted to the facility on 7/22/08 with symptoms that included Shortness Of Breath (SOB) related to a diagnosis of Congestive Heart Failure (CHF). Review of the nursing admission assessment dated 7/22/08 identified that Patient #18's skin was intact upon admission. Review of Braden score assessments dated 7/22/08 through 8/11/08 identified that Patient #18 was at risk to develop pressure ulcers. Physician orders dated 7/22/08 directed the use of a Bi-Pap via a full face mask. Progress notes dated 7/23/08 identified that Patient #18 used the Bi-Pap overnight but that the patient kept trying to remove the face mask complaining that it was "too tight." The documentation identified that although the mask was adjusted to where it was comfortable for the patient, the adjustment made the delivery of oxygen non-effective and that Patient #18 was subsequently placed in soft mitts overnight to prevent removal of the Bi-Pap mask. On 7/25/08, Patient #18 was noted to have pink skin at the bridge of the nose. No further assessments of the bridge of the patient's nose were documented for six days. On 8/1/08, the area on the bridge of Patient #18's nose was noted as a "scab" but lacked measurements of the area and/or a description of the surrounding skin. On 8/3/08, the documentation identified the same area as a "tear" with a scant amount of white, purulent drainage. The area was cleansed with saline and a Band-Aid was applied. The documentation dated 8/3/08 identified that Patient #18 was pulling at the Bi-Pap mask and was subsequently placed on one to one observation to prevent removal

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of the mask. On 8/4/08, the nose wound was described as a tear with separated edges but with no treatment documented. On 8/6/08, the area was again described as a tear with a scant amount of bloody drainage but lacked measurements of the area or a prescribed treatment. On 8/7/07 at 12:20 AM, the documentation identified the area on the bridge of the patient's nose as a pressure area and that a foam dressing (Allevyn) was applied. At 11:57 AM on 8/7/08, the area was described again as a tear that was red and scabbing. On 8/11/08 at 9:20 AM, Patient #18 was observed to have a large, uncovered area of eschar that covered the bridge of the patient's nose where the Bi-Pap full-face mask rested. Interview with the Wound Consultant, Clinical Nurse Specialist #2, at 10:00 AM identified that she had received an e-mail from the unit on the morning of 8/11/08 requesting a consult. Subsequent to surveyor inquiry on 8/11/08, an assessment of the area identified that Patient #18 had an unstageable pressure area with necrotic tissue/eschar on the bridge of the nose that measured 1.5 centimeters (cm.) by 2.0 cm. Review of the Respiratory Therapy Policy for Bi-Pap ventilation identified that skin integrity on the bridge of the nose should be monitored as pressure from equipment could potentiate skin breakdown but failed to direct the frequency of monitoring/assessment of the skin and/or where the ongoing assessments would be documented.

In addition, review of the clinical record dated 7/24/08 identified that Patient #18 had developed an area of erythema at the coccyx and that barrier cream was applied. On 7/25/08, the record identified that the Patient had a pressure ulcer at the coccyx but lacked documentation of a description, size or staging at the time of the observation. A hydrocolloid/Duoderm dressing was applied. On 7/29/08, the documentation identified that the patient's coccyx area was ecchymosed, excoriated, and that a Duoderm was in place. On 7/31/08, the documentation identified the area as "question Stage I pressure ulcer" but lacked documentation of measurements of the area or a description of the surrounding skin. On 8/1/08, the documentation identified the area as a Stage II pressure area with a scant amount of tan drainage and separated edges and a Duoderm was applied. On 8/2/08, the coccyx area was downstaged to a Stage I pressure area. On 8/3/08, the documentation identified that Patient #18 had a Stage II pressure area, that the area was cleansed with soap and water, and a Tegaderm dressing was applied. Documentation of measurements of the patient's coccyx pressure area were lacking until 8/4/08. The area was identified on 8/4/08 as a Stage II pressure area measuring 1.0 cm. by 0.5 cm. with surrounding erythema. On 8/5/08, the documentation identified the patient's skin was reddened and non-blanchable (Stage I) around the Duoderm dressing but lacked measurements of the non-blanchable area. On 8/8/08, Patient #18's pressure area was again downstaged to a Stage I pressure ulcer with separated edges. Subsequent to surveyor inquiry on 8/11/08, an assessment of the area identified that Patient #18 had a Stage II pressure ulcer on the coccyx that measured 1.0 cm. by 0.5 cm. with surrounding blanchable erythema.

d. Patient #24 was admitted to the hospital on 8/10/08 with dehydration and diarrhea.

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Review of the admission assessment identified that the patient's Braden score was a 14 (less than 18= high risk) and that the patient had a Stage I to the sacral area. Further review from 8/11/08-8/12/08 identified that the patient had a Stage I and a duoderm was applied. Review of the wound consult on 8/12/08 identified that the duoderm was removed and the patient did not have a pressure sore but a excoriation/fungal issue that was to be treated with Nystatin powder. Review of hospital policy identified that staging should not be used to describe excoriations. Interview with the Director of N2 on 8/12/08 identified that the patient did not have a pressure sore.

Interview with the facility's Wound Consultants on 8/11 and 8/12/08 identified that nursing staff had been directed not to downstage pressure ulcers in accordance with professional standards. The Wound Consultants stated that once a pressure ulcer was identified as a Stage II or above, that staff should not describe the wound as a lower stage but instead as healing at the same higher stage. Interview with the facility's Informatics Specialist on 8/19/08 identified that although facility staff had been instructed to review previous nursing assessments as part of a current assessment, limitations with the software system used by the facility did not easily enable a nurse to review past assessments and/or care plans. Review of the facility's Skin Care Protocols directed that if a wound was present, an assessment of location, staging, appearance of the wound and surrounding tissue, necrotic tissue, eschar and the presence of discomfort and/or pain associated with the wound should be provided and that the assessment and treatment of wounds be documented in the clinical record. The policy directed that this assessment be conducted upon admission and at least weekly or more frequently if there is deterioration in the patient's overall condition.

In addition, the facility had developed a turning clock poster to provide visual cues to alert staff to which patients required frequent turning and repositioning. Interview with the Vice President of Patient Care Services on 8/14/08 identified that she had directed all nursing units to utilize the turning posters as of May 2008. Although the turning clock posters were present on some units in the facility, they were not in place on North 3.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Services (1) and/or (f) Diagnostic and Therapeutic Facilities and/or (i) General (6).

6. * Based on clinical record reviews, review of facility policies, observations and interviews, the facility failed to revise the plan of care to address the potential for skin impairment due to medical equipment for three (3) patients, Patient's # 8, 18 and 19, who required use of oxygen via nasal cannula and/or a full-face Bi-Pap mask to treat respiratory distress and/or failed to ensure that the nursing care plan was updated to reflect Patient #27's current problems. The findings included:

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a. Patient #8 was readmitted to the facility on 2/10/08 with diagnoses that included End Stage Renal Disease (ESRD), Diabetes and a Stage IV pressure ulcer on the coccyx. Review of Braden score assessments dated 2/10/08 through 3/29/08 identified that Patient #8 was identified to be at risk to develop pressure ulcers. Review of the clinical record identified that Patient #8 developed an area of eschar behind the left ear on 2/14/08 where the patient's nasal cannula rested. The documentation identified that "soft padding" was placed behind the left ear. On 2/15/08, Patient #8's left ear area was reported as necrotic but lacked documentation of any intervention and/or treatment to the area. Review of the plan of care lacked revisions to the plan of care to address the potential for further skin impairment and/or interventions related to the patient's use of the nasal cannula. The clinical record lacked documentation of any further monitoring or treatment through the time of the patient's discharge on 3/29/08.

b. Patient #18 was admitted to the facility on 7/22/08 with diagnoses that included Congestive Heart Failure (CHF). Review of Braden score assessments dated 7/22/08 through 8/11/08 identified that Patient #18 was identified to be at risk to develop pressure ulcers. Physician orders dated 7/22/08 through 8/11/08 directed the use of a Bi-Pap with a full-face mask at night. Progress notes dated 7/23/08 identified that Patient #18 used the Bi-Pap overnight but that the patient kept trying to remove it complaining that it was "too tight." The documentation identified that on 7/25/08, Patient #18 was observed to have pink skin at the bridge of the nose but lacked a revision to the plan of care to address the potential for skin impairment and/or interventions related to pressure on the bridge of the patient's nose caused by wearing the Bi-Pap mask. The clinical record dated 7/23/08 though 8/10/08 identified multiple, inconsistent descriptions/assessments of Patient #18's skin integrity on the nose. Review of the plan of care lacked revisions to it to address the potential for further skin impairment and/or interventions related to the patient's use of a full face Bi-Pap mask. On 8/11/08 at 9:20 AM, Patient #18 was observed to have an unstageable pressure area with necrotic tissue/eschar on the bridge of the nose that measured 1.5 centimeters (cm.) by 2.0 cm. where the Bi-Pap full-face mask rested.

c. Patient #19 was admitted to the facility on 8/7/08 with diagnoses that included hepatic encephalopathy. A Braden Scale assessment dated 8/7/08 identified that Patient #19 was at high risk to develop pressure areas. Physician orders dated 8/9/08 directed the use of a B-Pap with full-face mask to treat the patient's respiratory distress. Observation of Patient #19 on 8/11/08 at 10:15 AM identified that the patient was wearing a full-face plastic B-Pap mask. The edges of the facemask appeared to be pressing into the patient's skin. Upon surveyor request, the edges of the plastic face mask were lifted by Clinical Nurse Specialist #2 to reveal linear demarcations as a result of pressure from the mask on the patient's bilateral cheeks. Review of the clinical record identified that although a care plan was developed to address the potential for skin impairment based on Patient #19's Braden score, the care plan lacked documentation to address the potential for skin impairment and/or interventions related to pressure on the patient's face caused by wearing the Bi-Pap mask. Interview with the Director of Critical Care/Respiratory

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Services on 8/11/08 at 3:10 PM identified that nursing and respiratory therapy staff would be responsible for assessments of patients for the potential for skin impairment as a result of medical/respiratory equipment but that the facility currently did not have a policy in place to direct how frequently monitoring should take place and/or where the assessments would be documented. In addition, the Director of Critical Care/Respiratory Services stated that the facility had soft, foam padded full face masks available for patients who required Bi-Pap but was unable to explain why the foam masks had not been provided to Patient's #18 and 19. Review of facility policies directed that the nursing care plan be kept current and accurate. Policies directed that the nursing staff was responsible for development and implementation of an individualized plan of care for assigned patients as well as modifications to the plan of care based on patient response and changing patient needs. In addition, policies directed that a care planning note be written more frequently if needed based on patient condition, changes in patient condition, and/or deviations for expected outcomes.

d. Patient #27 with a history of multiple pterygium syndrome including mental retardation and mild sleep apnea was admitted to the hospital on 12/17/07 with a diagnosis of impacted left hip fracture. Review of the admission nursing assessment dated 12/17/07 indicated that the patient had cognitive deficits, required assistance with mobility and was dependent on staff for activities of daily living. On 12/18/07, the patient underwent an open reduction and internal fixation of the hip. Review of nurse's notes dated 12/18/07 and 12/19/07 indicated that the patient had periods of restlessness and anxiety, was afraid to be alone and was resistant to care. Review of the clinical record dated 12/19/07 with RN #7 identified that Patient #27 had exhibited increased restlessness and agitation (pulling at lines, kicking, hitting staff and throwing things), and that she notified APRN #1 of the patient's behavior and subsequently obtained an order for Ativan 1 milligram intravenous push. The facility failed to develop a nursing plan of care to address the patient's behaviors and/or the patient's diagnosis of mild sleep apnea. In an interview on 9/4/08, RN #7 identified that although a care plan for the patient's behaviors was not documented, the patient had a 1:1 sitter and that a care plan for sleep apnea was not developed as the patient had no respiratory issues prior to the incident of 12/19/07 where she was found bradycardiac and a "Dr. Quick" was initiated. Review of the facility policy for Documentation of Nursing Care, identified that the nurse was responsible for identifying and documenting the appropriate nursing protocols or interventions associated with active problems on the care plan within eight (8) hours of admission with a review of the plan of care recorded every-shift.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (6).

7. Based on review of the clinical record, review of facility policies, review of facility documentation, observations and interviews, the facility failed to ensure that the interagency

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referral form and the discharge summary reflected complete and/or accurate information for one (1) patient, Patient #6, who developed a Stage II pressure ulcer during the hospitalization. The findings include:

a. Patient #6 was admitted to the facility on 10/26/06 with diagnoses that included an exacerbation of Congestive Heart Failure (CHF). Review of the nursing admission assessment dated 10/26/06 identified that Patient #6's skin was intact upon admission. Review of Braden score assessments dated 10/26/06 through 11/2/06 identified that Patient #6 was identified to be at risk to develop pressure ulcers with scores that ranged from thirteen (13) to seventeen (17). The clinical record identified that four days after admission on 10/30/06, barrier cream was applied to the patient's buttocks. On 11/1/06, the documentation identified that Patient #6 had developed a Stage II pressure ulcer on the coccyx and that a Duoderm dressing was applied. Patient #6 was discharged to Extended Care Facility #1 (ECF #1) on 11/2/06. Review of the interagency referral form and the discharge summary both dated 11/2/06 lacked documentation of Patient #6's pressure ulcer and/or treatments to the area. Review of the nursing admission assessment from ECF #1 dated 11/2/06 at 1:30 PM identified that Patient #6 arrived at the facility with a Stage II pressure ulcer on the right buttocks that measured 1.0 centimeters (cm.) by 0.5 cm. with excoriation over both the right and left buttocks and coccyx area. Interview with the Clinical Nurse Specialist #2 and the N3 Nursing Director on 8/12/08 at 2:30 PM failed to identify an explanation for the lack of documentation on Patient #6's discharge communications but identified that the information should have been documented. Review of facility policies directed that the physician is responsible for completing the interagency referral form and the dictated summary. In addition, the policy directed that nurse assigned on the day of discharge is responsible for assuring that the discharge plan is completed, and that a verbal/telephone report by the nurse be given to the extended care facility

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Services (1) and/or (i) General (6) and/or (l) Infection Control (1)(A).

8. * Based on review of the clinical record, review of facility policies, review of facility documentation, observations and interviews, the facility failed to ensure that wound care was provided in accordance with facility policies and/or infection control standards for one (1) patient, Patient #18, who developed an unstageable pressure ulcer on the bridge of the nose due to pressure from a Bi-Pap mask and a Stage II coccyx pressure ulcer. The findings include:
   a. Patient #18 was admitted to the facility on 7/22/08 with diagnoses that included Congestive Heart Failure (CHF). Review of the clinical record dated 8/4/08 identified that Patient #18 had developed a Stage II pressure area on the coccyx. In addition, the documentation dated 8/7/08 identified that Patient #18 had developed a pressure area on the bridge of the nose related to use of a full face Bi-Pap mask. Observation of Patient

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#18's wound care in the presence of the facility's wound consultant, Clinical Nurse Specialist #2, on 8/11/08 at 10:45 AM identified that RN #5 applied clean gloves, cleansed the pressure area on the patient's nose with Normal Saline (NS), wiped away a scant amount of serosanguineous drainage, and applied a hydrocolloid dressing. Without the benefit of washing her hands or changing her gloves, RN #5 repositioned Patient #18 and began treatment to the patient's coccyx pressure ulcer. A small amount of soft stool was observed at the patient's rectal and lower coccygeal areas. RN #5 used a NS soaked gauze to wipe away the stool, folded the gauze in half, and proceeded to continue to wash upwards from the patient's coccygeal area, up and over the patient's Stage II pressure area, and across the coccyx. Interview with RN #5 by the Clinical Nurse Specialist #2 following the observation identified that RN #5 thought she had changed her gloves prior to moving from one wound dressing to the other. RN #5 stated that because she had folded the gauze in half before cleansing the coccyx wound, she believed she avoided having the stool come in contact with the wound. Interview with Clinical Nurse Specialist #2 following the observation identified that RN #5 failed to provide the dressing change in accordance with facility policies and infection control standards and that RN #5 was immediately re-inserviced. Review of the facility's Infection Control policies directed that wound care be provided using clean technique that includes meticulous handwashing, a clean field, clean gloves, and prevention of direct contamination of materials and supplies.

In addition, interview with Patient #18's family member, Person #3, on 8/11/08 at 10:45 AM identified that she used hydrocolloid dressings she had brought in from home to treat the area on the patient's nose. Review of the documentation in the nursing clinical assessment record identified that Person #3 provided dressing changes to the bridge of the patient's nose on 8/5/08 and again on 8/6/08. Interview with Nurse Manager #3 on 8/19/08 identified that she was unaware that Person #3 had provided the treatment to the patient's pressure area or that there was documentation of the family member providing treatment in the clinical record. Nurse Manager #3 stated that facility policy directed that the assigned nurse was responsible for the patient's care and that policies did not allow non-staff members to provide wound treatments.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical Plant (4) and/or (b) Administrator (2) and/or (i) General (6) and/or (l) Infection Control (1).

9. Based on review of facility policies, documentation, observation and interviews, the facility failed to secure entry to the Sterile Processing Department (SPD) and/or maintain the department's physical environment and/or provide documentation that the Sterile Processing Department Manual was reviewed and/or revised on a yearly basis. The findings include:
   a. A tour of the SPD was conducted on 8/14/08 with the Supervisor of the SPD. Observation of the Sterrad room at 9:30 AM identified that the outer door that led to the main hallway was ajar rendering the room accessible without the use of key or employee

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badge. Interview with the Supervisor of SPD at 9:32 AM on 8/14/08 noted that all areas of the SPD required authorized entry from the main hall. The Sterrad room was considered a clean room and proper airflow should be maintained (door kept completely closed). Review of the SPD policy and procedure manual for infection control for SPD identified that access to SPD will be by employee badge or key. All areas must be secure with controlled access.

b. Observation of the Sterrad room at 9:30 AM identified that one wall of the room had two holes through the sheetrock approximately 1 to 2 inches in diameter. Interview with the Supervisor of SPD at 9:32 AM on 8/14/08 noted that a shower had been removed from the room approximately 2 months ago and the area of the wall that the shower pipes had entered had never been repaired despite requests made to the Operations Management Department. Review of the SPD policy and procedure manual identified that air pressure in clean processing (Sterrad room) and sterile storage area must be positive. Subsequently, the Engineering Department repaired the holes on 8/15/08.

c. The SPD policy manual was reviewed with the SPD staff on 8/14/08. A signature sheet in the front of the manual was dated 10/1/04 and identified that this was the date that the manual was issued and/or revised and/or reviewed. The most current policy added to the manual was dated 12/06. Interview with the SPD Manager on 8/18/08 indicated that the signature sheet was no longer required as of 2006 after the hospital merged with an affiliated hospital. Although SPD policies and procedures identified that the policies in the manual were to be reviewed on a yearly basis by the Manager of SPD and revisions made as needed, the facility was unable to provide documentation that this had been done.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(A) and/or (B) and/or (e) Nursing Services (1) and/or (i) General (6).

10. * Based on a medical record review, review of hospital policy, procedures, documentation, and interviews for 1 patient who was suicidal (Patient #12), the facility failed to ensure that the patient's behavior was assessed/ diagnosed by the psychiatric physician. The findings include:

a. Patient #12 was admitted to the Emergency Department on 2/17/08 for opiate dependence and suicidal remarks. Physician orders dated 2/17/08 at 10:21 PM directed crisis intervention consult. The Crisis Intervention Nurse, RN #13 assessed the patient on 2/18/08. Documentation by RN #13 (Crisis ER Short Form) dated 2/18/08 identified that the patient had an Axis I mental disorder diagnosis of substance induced mood disorder/opiate dependency. Documentation further identified that the patient was discussed and reviewed with both the psychiatrist and the ED physician. A physician did not sign the consult form or come in to evaluate the patient. Interview with the Chief of Psychiatric Services on 8/15/08 at 11:35 AM noted that the crisis nurse assesses the patient, gathers information and discusses the findings with the psychiatrist and the ED physician. The psychiatrist would not necessarily speak with the patient. Interview with the psychiatrist on 8/19/08 at 9:30 AM noted that the nurse gathers patient information,

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assesses the patient and then calls the psychiatric attending. He indicated that if a patient were in the ED greater than 24 hours, the psychiatrist would go to the ED and would document the visit. Interview with RN #13 on 9/2/08 at 10 AM noted that the patient's diagnosis information was obtained from the patient, the patient's family and the behavioral program that referred the patient. The record failed to document that the psychiatric physician developed the diagnosis for the patient. The medical staff rules and regulations identified in part that the attending/consulting or covering physician must sign all consult reports.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6).

11. Based on medical record review, review of hospital policies, procedures, documentation, and interviews, the facility failed to reassess the patient's pain and/or ensure that the physician was notified timely of the patient's unacceptable response to pain medication and/or administer pain medication timely to Patient #13. The findings include:
    a. Patient #13 had a diagnosis of Sickle Cell Disease and was admitted to the Emergency Department (ED) on 6/22/07 with complaints of chest pains and difficulty breathing. ED Physician orders dated 6/33/07 directed Dilaudid 2milligrams IV/IM for pain. Nursing documentation identified that the patient ' s pain score was a level "10" at 2:54 AM on 6/22/07 and the Dilaudid was administered IV push. Although the patient reported a pain level of "6" after the medication administration, the record lacked documentation that the physician was notified of the patient ' s continued complaints of pain. At 4:07 AM the patient ' s pain level was documented as a level "9", the physician was notified, and the medication was ordered and administered at 4:13 AM. Interview with the ED Nursing Director on 8/19/08 at 10:30 AM noted that when relief of pain after pain medication was not obtained, the nurse was expected to report this to the physician and the physician would reassess the patient. He further indicated that assessments after IV medications were performed 15- 30 minutes after the administration.
    b. Nursing documentation and medication records for Patient #13 dated 6/25/07 noted that the patient had a target pain score of "2". The medication record identified that the patient received pain medication at 12:10 AM and 3:10 AM, and was reassessed to be a level "5"after each intervention. Nursing narratives dated 6/22/07 at 3:41 AM indicated that the patient was yelling out with complaints of pain yet lacked documentation that the physician was notified of the patient ' s unacceptable pain levels following each reassessment. The facility pain policy identified to administer pain analgesics as ordered and to collaborate with the physician in titrating medications until pain level is acceptable to the patient. The institution standard is less than or equal to "3" but, the patient may state a different personal goal for control.
    c. Patient #13 had a diagnosis of Sickle Cell Disease and was admitted to the Emergency Department (ED) on 6/22/07 with complaints of chest pains and difficulty breathing. The ED triage record identified that the patient arrived at the ED at 12:17 AM and was

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triaged as an urgent admission with a pain score level of "9" on a scale of 1-10. Although the physician assessed the patient at 1:11 AM, physician orders for pain control (Dilaudid 2 milligrams IV/IM (intravenously/intramuscularly), were not written until 1:49 AM on 6/22/07 and nursing documentation identified that the medication was not administered to the patient until 2:54 AM (1 hour and 5 minutes after order) and was administered IV. Interview with the ED Nursing Director on 8/19/08 at 10:30 AM in indicated that although the patient had an implanted catheter port for IV access, ED nurses were not trained to access these ports. He identified that the IV Nurse could access implanted ports but that one IV Nurse covered the entire hospital.

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (d) Medical Records (8) and/or (i) General (6).

12. * Based on review of the clinical record, interviews, review of hospital policy and procedures and review of hospital documentation for one patient that required consent for care and services (Patient #5), the hospital failed to obtain consent for care and services that were provided and/or failed to ensure that the hospital's informed consent form was utilized as per medical staff rules and regulations for Patient #28. The findings include.
    a. Patient #4 was admitted to the hospital on 3/19/08 with premature rupture of membranes at 38 weeks and three days pregnant. Review of the clinical record reflected that on 3/20/08 at 12:40 A.M. Patient #4 experienced chills, was shaking and had a temperature of 101.6 degrees Fahrenheit (normal is 98.6 degrees Fahrenheit). The patient's physician directed the staff to administer two antibiotics, which were administered intrapartum. On 3/20/08 at 12:57 A.M. Patient #4 delivered a baby (Patient #5). Review of Patient #5's clinical record reflected that on 3/20/08 at 6:00 A.M. Patient #5's temperature was 96 degrees Fahrenheit. On 3/20/08 at 6:45 A.M. PA #1 transferred Patient #5 to the Special Care Nursery (SCN) for a sepsis work-up and treatment. Review of the clinical record failed to reflect that Patient #5's parents were informed of the patient's change in condition, the need to transfer Patient #5 to the SCN or granted permission/consent to perform diagnostic tests to treat Patient #5. Interview with PA #1 on 8/12/08 identified that he transferred Patient #5 to the SCN, began the sepsis workup-including blood work, a chest x-ray and blood cultures. Intravenous antibiotic medications and intravenous fluids were administered to Patient #5. PA #1 added that after the procedures were performed and treatment was started he then informed Patient #5's family of the patient's change in condition, the need for transfer to the SCN, the diagnostic tests that were completed and the treatments that had been started. Interview with MD #6, the Director of the SCN, on 8/12/08 identified PA #1 should have explained to Patient #5's parents the patient's change in condition, the need to transfer the patient to the SCN and the diagnostic tests completed (as part of the sepsis work-up) prior to a transfer and/or any initiation of care and/or treatment. Interview with the Hospital General Counsel on 8/11/08 identified that on admission, the expectant mother signs the hospital "Consent Form" which is consent to treat her only. Review of the Hospital policy and procedure, titled "Patient Rights and Responsibilities", identified that each patient has the right to be informed of his/her condition, participate in the development of his/her treatment and be treated with respect courtesy and dignity. In addition review of the Hospital's "Rules and Regulations of the Medical Staff", 11/29/07 version, page 33, in the event of a significant change in condition the attending practitioner will notify the patient's family.
    b. Patient #28 arrived to the hospital's Endoscopy Unit on 1/9/08 at 9:10 am for an Endoscopy and Colonoscopy with possible biopsy with moderate sedation. Although

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review of the clinical record with MD #19 (Gastroenterologist) identified that Patient #28 had signed MD #19's informed consent for these procedures in his office on 11/13/07, MD #19 failed to ensure that the hospital's consent for Endoscopic procedures was completed prior to these procedures on 1/9/08. During an interview on 9/9/08, MD #19 stated that he utilized the informed consent form from his practice which was detailed and specific. Review of the Medical Staff Rules & Regulations identified that the hospitals informed consent form must be filled out in its entirety and that the physician should personally obtain the patient's signature following discussion of the contemplated procedure.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (i) General (6) and/or (l) Infection Control (1).

13. * Based on review of the clinical record, interviews and review of hospital policy and procedures for one patient that required a central venous access for care and services (Patient #2), the hospital failed to remove the central venous access in a timely manner.
    a. Patient #2 was admitted to the hospital via the Emergency Department (ED) on 3/1/07 with the complaints of a bloody cough, which required immediate intubation and mechanical ventilation and was diagnosed with respiratory failure. Patient #2's medical history included Hodgkin's lymphoma, Methicillin Resistant Staphylococcus Aureus pneumonia, chronic renal failure, depression, Hepatitis C, vasculitis, liver mass, heart block, uremia and thrombocytopenia. Review of the clinical record identified that on 3/13/07 at 5:25 A.M., Patient #2 experienced seizures, a heart rate of 30-40 beats per minute (normal heart rate is 60-80 beats per minute) and was not responsive. At that time, the staff began resuscitation efforts, including insertion of central venous access of a triple lumen catheter in the left femoral vein and the patient was transferred to the critical care unit. Patient #2's hospital stay was complicated-including a persistent fever. On 3/15/07 Patient #2 was transferred from the critical care unit to the medical floor. On 3/24/07 the left femoral central venous access was discontinued and the catheter tip was sent for culture. The culture identified that the central venous catheter had a Methicillin Resistant Staphylococcus Aureus infection. Patient #2 was treated with two intravenous antibiotics starting on 3/24/08 and finishing on 3/29/08 (the patient had been on another antibiotic medication from 3/5/07 to 3/13/07). In addition the clinical record, dated 3/31/07, identified that Patient #2 required hemodialysis treatment for worsening renal failure and treatment for a complete heart block. At that time the patient's family decided not to pursue any further treatments and Patient #2 was pronounced dead on 3/31/07 at 6:20 P.M. Review of the Certificate of Death for Patient #2 identified that the causes of death were cardiac failure (heart block), renal failure, bacteremia and underlying valvular heart disease. Interview with the Infection Control Nurse on 8/13/08 identified that Patient #2's central venous access line sepsis developed due to

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the prolonged period that the left femoral central venous access line was left in place. In addition, the central venous access line should have been removed earlier and central venous access lines should be discontinued after 2 days. Interview with MD #7, the patient's attending physician, on 8/14/08, identified that the central venous access line sepsis could have been a contributing factor in the patient's death. Interview with the Hospital's Chief Medical Officer on 8/18/08 identified that after central venous access lines are placed emergently, the central venous access lines are replaced when the patient arrives in the critical care unit. Review of the record reflected that the left femoral venous access line was in place from 3/13/08 to 3/24/08 and the clinical record failed to identify documentation to reflect the ongoing need for this central venous access, the potential risk of infection from this access and/or the potential risk of complications from the access. Review of the Hospital policy and procedure, titled "Central Venous Access Device, Care of the Patient with", identified that the triple lumen catheter is a "short-term" access for acute illness and/or immediate access.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical Records (3) and/or (e) Nursing Services (1) and/or (i) General (6).

14. * Based on a review of medical records, review of facility policies, and interviews with hospital staff, the facility failed to ensure that the clinical records were accurate and/or complete for Patient #28, #29, #38, #39. The findings include:
    a. Patient #29 arrived to the hospital's emergency department (ED) on 4/26/08 at 12:00 pm with a chief complaint of chest pain. A physician's order dated 4/26/08 at 12:14 pm directed that an electrocardiogram (EKG) be performed. Review of the EKG report dated 4/26/08 identified that the test was performed at 10:42 am although the patient had not arrived to the emergency room until 12:00 pm. Review of the clinical record and interview with the ED Nurse Manager on 8/21/08 identified that the time on the EKG report was incorrect and was unable to identify why this occurred. Review of the clinical record with the Nurse Manager of the ED identified that MD #18 ordered medications that included Aspirin, Nitroglycerine, Lopressor, Ativan, a GI Cocktail, and Plavix. Review of the time that the medications were ordered compared to the time the medications were identified as administered identified a delay up to thirty-three (33) minutes. Record review and interview with RN #9 (nurse assigned to the patient) identified that although he administered the medications immediately, the computerized record documents the time the record is accessed and doesn't reflect the actual time the medications were administered. RN #9 identified that free texting into the system is an option. Further review of the clinical record identified that MD #18 requested a cardiology consultation at 1:50 pm. Interview with MD #18 identified that 1:50 pm was the time the consult was entered into the computer, however, he requested the consult

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when he received the patient's Troponin level back from the laboratory. Review of the laboratory results dated 4/26/08 identified that lab personnel notified MD #18 of the patient's Troponin level at 1:21 pm. The hospital failed to ensure that the clinical record accurately reflected the time in which the consult was requested. Patient #29 was admitted to the hospital's Intensive Care Unit (ICU) on 4/26/08 at 3:48 pm with a diagnosis of Acute Coronary Syndrome. Review of the clinical record and interview with RN #8 on 8/20/08, identified that at 4:38 pm, she notified MD #13 (Cardiologist) that the patient continued with chest pain, rated as a three (3) on a scale of 1-10 (10 being the worst possible pain), despite the Nitroglycerine drip (60 mcg/min) and administration of IV morphine (5 mg). MD #13 subsequently ordered a repeat Troponin level and an EKG. At 5:34 pm, RN #8 documented that MD #13 was at the patient's bedside. During an interview on 8/22/08, MD #13 identified that the patient's second Troponin level was elevated to 1.07 nanograms per milliliter (ng/ml) at 4:50 pm (from 0.309 ng/ml at 12:20). Based on the patient's continued level of pain, MD #13 offered to perform a cardiac catheterization at Acute Care Hospital #3, however, the patient and/or family requested the catheterization be performed at Acute Care Hospital #2. Although MD #13 reassessed the patient, he failed to document his assessment and/or plan of care during that period of time. Review of the Medical Staff Rules & Regulations identified that pertinent progress notes should be recorded at the time of observation, sufficient to permit continuity of care and transferability.

b. Patient #28 arrived to the hospital's Endoscopy Unit on 1/9/08 at 9:10 am for an Endoscopy and Colonoscopy. Review of the clinical record with RN #11 identified that post-procedure, Patient #28 complained of increased epigastric pain and stated that she informed MD #19 of the patient's complaint. RN #11 identified that MD #19 came to the unit and subsequently prescribed Levsin (anti-spasmotic) 0.125 milligrams sublingually. Review of the clinical record lacked documentation that MD #19 assessed the patient. In an interview on 9/9/08, MD #19 stated that although he assessed the patient, he did not write a note. Further review of the clinical record identified that Patient #28 was discharged home at 12:00 pm, experienced increased epigastric pain and shortness of breath while at home and returned to the hospital's Emergency Room at 1:54 pm and subsequently diagnosed with a perforated esophagus. Review of the Medical Staff Rules & Regulations identified that pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Review of the clinical record indicated that the procedure began at 10:00 am and ended when the scope was removed from the patient at 10:20 am. Review of the post-anesthesia recovery scores that assess the patient's level of consciousness, respiratory status, circulatory status, activity, and patient's color (Aldrete score) identified that RN #11 documented a score of ten (10) at 10:20 am (when the scope was removed) although she was not present during the procedure. In an interview on 8/19/08, RN #11 stated she based her assessment on review of the patient's vital signs during that period of time and report she received from the nurse who cared for the patient during the procedure. In an interview on 8/20/08, the Director of the Endoscopy Unit identified

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that Aldrete assessments begin when the patient is received in the recovery room. Review of the Documentation of Nursing Care policy identified that each entry must contain the time of entry and documentation of actual time of observation. In addition, review of the patient's Aldrete assessments during the period of "in" (arrival to recovery room) to "out" (discharge from the Unit) failed to reflect the time at which the assessments were conducted as the scores were documented in blocks of time (e.g. arrival to unit, 15, 30, 45, 60 minutes and discharge). Review of the facility policy's provided to the surveyor, failed to provide direction to staff on the completion of Aldrete assessments. In an interview on 8/20/08, the Director of the Endoscopy Unit identified that Aldrete assessments begin when the patient is received in the recovery room and are documented every fifteen-minutes (15) for thirty-minutes (30) or until the patient reaches their baseline assessment.

c. Patient #38 and Patient #39 had Endoscopic procedures on 8/19/08. Review of their medical records on 8/20/08 with the Director of Endoscopy identified that although Aldrete assessments were conducted, the time of these assessments were not documented.

d. Patient #27 with a history of multiple pterygium syndrome including mental retardation was admitted to the hospital on 12/17/07 with a diagnosis of impacted left hip fracture and on 12/18/07 underwent an open reduction and internal fixation of the hip. Review of the clinical record dated 12/19/07 with RN #7 identified that Patient #27 had exhibited increased restlessness and agitation (pulling at lines, kicking, hitting staff and throwing things), and that she notified APRN #1 of the patient's behavior and subsequently obtained an order for Ativan 1 milligram intravenous push. In an interview on 9/4/08, RN #7 stated that although she attempted to obtain the patient's vital signs prior to administration of Ativan in accordance with hospital policy, the patient was too agitated and refused his vital signs be taken. Review of the clinical record lacked documentation that identified the patient's refusal and/or that additional attempts were made to obtain the patient's vital signs prior to the administration of Ativan.

<u>The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2) and/or (d) Medical Records (3) and/or (e) Nursing Services (1) and/or (i) General (6).</u>

15. Based on a review of the medical record, interviews with hospital staff, review of the facility policies and/or review of the Medical Staff Rules & Regulations, the facility failed to ensure that the Physician, prior to the intended procedure, completed the History & Physical and/or failed to ensure that the Physician and Registered Nurse completed the pre-procedure assessment for Patient #28. The findings include:

    a. Review of Patient #28's History & Physical failed to reflect documentation that MD #19 completed a detailed examination relative to the proposed procedure in accordance with the hospital's Medical Staff Rules & Regulations. In addition, MD #19 failed to ensure

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that the Pre-procedure assessment was completed in that the assessment failed to identify when the patient last consumed food and/or fluids and lacked a physician's signature, date and time. During an interview on 9/9/08, MD #19 stated that nursing would address the NPO (nothing by mouth) status on their assessment. Review of the Nursing Pre-procedure assessment failed to indicate when the patient last consumed food and/or fluids. Review of the facility's Criteria for Initial, Ongoing, and Discharge Assessment and Management directed that the patient's food and fluid status would be documented.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(E).

16. Based on review of credentialing files and interviews with facility personnel, the facility failed to ensure that one physician's credentialing files were current. The findings include:
    a. Review of credentialing file of Radiologist #1 identified that he was credentialed as provisional associate attending radiologist on 11/30/07 and would need to be reviewed in 6 months. Further review failed to identify that the 6 month review was completed. Interview with the Vice President of Medical Affairs on 8/20/08 identified that the radiologist was overdue to be reviewed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (4) and/or (f) Diagnostic and Therapeutic Facilities and/or (i) General (6).

17. * Based on clinical record reviews and interviews with facility personnel for one sampled patient (Patient #10), the facility failed to ensure that radiology staff were notified when a pregnant patient was exposed to radiation. The findings include:
    a. Patient #10 was admitted to the hospital on 2/22/08 for a laparoscopic extensive enterolysis and chromopertubation. Patient #10's post operative course was uneventful and was discharged to home on 2/22/08. On 2/28/08 (6 days later), Patient #10 was complaining of pain and a distended abdomen. Patient #10 was sent for a CT scan with contrast that showed large amounts of free fluid in the abdomen and fluid collection within the right abdominal musculature. Further review identified that on 3/2/08 (3 days later), the patient had a abdominal x-ray that demonstrated ascites and mild central small bowel dilation and of concern was an ileus or early small bowel obstruction. Review of the laboratory results dated 3/2/08 identified that the patient had a positive pregnancy test. Subsequently, on 3/6/08, Patient #10 was diagnosed with a bladder perforation and underwent cystoscopic, bilateral retrogrades and a bladder repair, and on 3/19/08 had

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the pregnancy terminated due to exposure to high doses of radiation and anesthetic medications. Review of hospital policy identified that the radiation physicist and nuclear medicine radiologist on duty will be immediately notified if any patient is found to be pregnant after a nuclear medicine or radiology exam and will have fetal dose calculations completed based on the exposure of the specific exam performed. Further review identified that the patient's ordering physician will be immediately notified after the calculations have been performed regarding what processes may need to be taken for the patient. Interview with MD #26 identified that he never notified the radiologist of Patient #10's exposure to radiation and CT scan contrast dye.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (4) and/or (f) Diagnostic and Therapeutic Facilities and/or (i) General (6).

18. * Based on clinical record reviews and interviews with facility personnel for one of one sampled patient (Patient #10), the facility failed to provide radiologic services of sufficient scope and complexity. The findings include:
    a. Patient #10 was admitted on 2/28/08 for an abdominal and pelvis CT with contrast at an out patient facility. On 3/2/08, complete abdominal x-rays including supine and erect views were completed. On 3/6/08 a retrograde urogram was performed in the operating room with the use of fluoroscopy during which four screen captured images were obtained. On 3/9/08, Patient #10 was discharged. Review of the progress notes identified that MD #26 discussed the possibility of pregnancy termination based on laboratory results from 3/2/08 and 3/5/08, that determined that Patient #10 was positive for Endocrine Fertility Beta HCG test. Further review identified that this information was not made available to health care providers. Review of hospital policy identified that the radiation physicist and nuclear medicine radiologist on duty will be immediately notified if any patient is found out to be pregnant after having a nuclear medicine or radiology exam and have fetal dose calculations completed based on the exposure of the specific exam performed. Further review identified that the patient's ordering physician will be immediately notified after the calculations have been performed regarding what processes may need to be taken for the patient. Interview with the Director of Radiology Services identified that fetal dose calculations were not performed according to hospital pregnancy policy.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (f) Diagnostic and Therapeutic Facilities and/or (i) General (6).

19. Based on observations and interviews with facility personnel, the facility failed to ensure that emergency equipment utilized in MRI was maintained. The findings include:

EXHIBIT A

DATES OF VISITS: Commencing on August 11, 2008 and concluding on September 3, 2008

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a. During tour of the MRI area on 8/18/08 it was identified that the code cart was not checked. Further review identified that from 10/07-8/08 code cart checks were not completed. Review of hospital policy identified that code cart checks are to be completed daily. Interview with the Director of Radiology on 8/18/08 identified that the MRI area was a contracted service and that the code cart was to be checked daily.

EXHIBIT B
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FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.